PRINTED: 11/09/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUIND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUIND PLAN OF CORRECTION (X3) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR			(X3) DATE COMF	(X3) DATE SURVEY COMPLETED		
		435042	B. WING _		10/	28/2021
	ROVIDER OR SUPPLIER	RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		
	42 CFR Part 483, Sul Long Term Care facility 10/26/21 through 10/3 Manor Retirement Cocompliance with the f Bedrails CFR(s): 483.25(n)(1): §483.25(n) Bed Rails The facility must atternatives prior to in a bed or side rail is uscorrect installation, us rails, including but no elements. §483.25(n)(1) Assess entrapment from bed §483.25(n)(2) Review bed rails with the resire presentative and of to installation. §483.25(n)(3) Ensure are appropriate for the §483.25(n)(4) Follow recommendations an and maintaining bed This REQUIREMENT by: Surveyor: 41088 Based on observation and policy review, the	mpt to use appropriate installing a side or bed rail. If sed, the facility must ensure se, and maintenance of bed it limited to the following is the resident for risk of rails prior to installation. If the risks and benefits of ident or resident orain informed consent prior If that the bed's dimensions we resident's size and weight. If the manufacturers' d specifications for installing rails. If is not met as evidenced In, interview, record review, we provider failed to ensure		Restraint Policy N-554 reviewed an include: Review risks and benefits of some bars with resident and/or represent and obtain an informed consecting installation of side rails/ grab. Attempt to use appropriate all prior to installing side rail / gray assess resident for risk of entitle bed rail prior to installation. Ensure the bed's dimensions appropriate for the resident's weight. Manufacturers' recommendates specifications for installing an side rails/ grab bars is followed. Pre-restraint assessment intervent list will be completed on all new act starting with the next new admission.	side rails/grab resentative ent prior to bars. ternatives ab bar. trapment from are size and d maintaining ed. tion and check	
ROBATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE
Tom .	Snyder			Administrator		11/17/2

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UFGF11

Facility ID: 0059

If continuation sheet Page 1 of 8

	OF DEFICIENCIES F CORRECTION			(X3) DATE COMP	SURVEY LETED	
		435042	B. WING		10/28/2021	
	ROVIDER OR SUPPLIER OTHER JOSEPH MANOR	RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 700	16, 31, 44 and 57) who beds. Findings included 1. Observation on 10/resident 11's bed revethe head of the bed. *The side rail by the viposition and the other Interview on 10/27/21 11 revealed: *She had used the side herself in bed. *The side rails had be admission. *She could not rememprovided for risks of the consent form for their Review of resident 11 *She had been admitt *Her brief interview fo 15 and indicated her of the A 2/15/21 physician of bed mobility. *Her last revised care rails for bed mobility. 2. Observation and intal a.m. with resident 16 the toup. *Used the side rails to assisted her with care	were completed and 8 sampled residents (4, 11, 10 had side rails on their expenses; 27/21 at 9:43 a.m. of called bilateral side rails near wall was in the upright raide rail was down. at 9:45 a.m. with resident de rails for positioning then on her bed since her education being the bed rails or signing a tuse. It is medical record revealed: the don 2/15/21. The mental status (BIMS) was cognition was intact. The plan stated she used side thereign on 10/26/21 at 7:55 revealed she: The bed with bilateral side rails were thold herself up when staff	F 70	All current Residents, including but not li residents (#4,11,16,31,44 & 57) will hav side rail / grab bar assessment complete EMR by 12/14/2021. Side rails/grab bars will be removed from by 12/14/2021. If side rails/grab bars are to be removed from bed, they will be see the down position. If side rail or grab bar deemed necessary will remain on the bed and an assessme be done by DON, ADON or designee me to insure gaps/widths between handles of devices and space between mattress an rail are less than 4 ¾ inches, per policy the decrease risk of entrapment by 12/14/200. Care Plans will be reviewed, revised and individualized for all residents to reflect she grab bar use or non-use by 12/14/2021 and quarterly and with change of condition thereafter. All beds utilized by Residents will have an inspection by DON, ADON or designee the ensure dimensions are appropriate for the Residents size and weight by 12/14/2021 annually going forward. Maintenance to inspect all beds containing rails / grab bars to assure manufacturers recommendations and specifications for installing and maintaining bed rails is corby 12/14/2021, then annually thereafter we checks. Education will be provided to all nursing staff Development Coordinator or design restraints and side rail/bed rail policies by 12/14/2021.	ye a d in h beds unable unable ured in y, they nt will easuring on d side o 21. ide rail/ and then n initial o e 1, then ng side mpliant with PM staff by see on	12/14/2021

CENTER	S FOR MEDICARE &	VIEDICAID SERVICES					
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE : COMPI	
		435042	B. WING _			10/2	28/2021
	ROVIDER OR SUPPLIER OTHER JOSEPH MANOR	RETIREMENT COMMUNITY		16	TREET ADDRESS, CITY, STATE, ZIP CODE 002 NORTH JAY STREET BERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 700	regarding risks of the signed a consent for the signed and the bed rails of the bed, and the bed rails for the signed and the bed rails of the signed and the bed rails of the signed and the bed rails on 10/2 right position.	cation being provided bed rails or if she had their use. 7/21 at 9:31 a.m. of resident es closed with both side rails of the second revealed: ted on 12/13/20. Spice since May 2021. 10 indicating she had a mpairment. 1's order for side rails to aid e plan stated she used side 7/26/21 at 8:05 a.m. and with resident 31 in a bed so, her eyes closed and both 1's medical record revealed: ted on 6/9/21.	F	700	Monthly audits of Pre-restraint Assessm completion compliance on all new admis will be completed by DON, ADON or desized months. Monthly audits of informed consent obtause of side rail/grab bar (bed mobility) onew admits will be completed by DON, Adesignee x6 months. Monthly audits of care plans for resident side rails / grab bars on all new admits with completed by DON, ADON or designee assure documentation is on the care plastide rail/grab bar (bed mobility) x6 month. Ten (10) monthly audits will be complete DON, ADON or designee of staff complimith appropriate use of side rails/grab bar mobility) x6 months. Audits will be reported quarterly x2 to the Committee by ADON or until advised to discontinue reporting by QAPI Committee.	signee signee ined for on all ADON or s with vill be to n for ths. ed by ance ars (bed	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		ATE SURVEY DMPLETED
		435042	B. WING		.	10/28/2021
	ROVIDER OR SUPPLIER OTHER JOSEPH MAN	OR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 700	they are in bed for *For more informat plans for specific ir should be one or bethe resident. Interview on 10/28, 57 revealed: *She used the side *The bed rails assi and change positio *They do not bothe *The staff put the bed each night. Review of resident *She had been addred *Her BIMS score we cognitively intact. *A 1/6/21 physiciar to enable bed mob *Her last revised carails for bed mobilit Review of the above specific information rails for the resident -There was no mer both was to be use -There was no mer condition had promails. Review of the med residents revealed:	cona) E revealed: rails up for all the residents if safety so they did not fall. ion they looked at the care instructions such as if there oth side rails up or down for 21 at 10:44 a.m. with resident e rails every day to get into bed. It has the to be able to turn over in. It her. It is record revealed: Inited on 1/6/21. It is 15 indicating she was a order for side rails to be used illity and transfers. It is care plan stated she used side by and transfers. It is care plans revealed no in about placement of the side ints. Intion of whether one side rail or indicating of the side into its intion of what diagnosis or in pred the need for the side its is sessments had not been	F 700			

NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY (XA) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 700 Continued From page 4 -The risks and benefits had been reviewed with the resident or their representativeThe provider received signed consent for side rails before their use. "Appropriate alternative interventions had been attempted prior to side rails being used. Surveyor: 43021 5. Observation and interview with resident 44, on 10/26/21 at 10:45 a.m. revealed: "Bilateral side rails towards the head of her bed. "She has side rails towards the head of her bed. "She does not recall staff discussing the risks and benefits of using the side rails.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IG			(3) DATE SURVEY COMPLETED	
AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 700 Continued From page 4 -The risks and benefits had been reviewed with the resident or their representative. -The provider received signed consent for side rails before their use. *Appropriate alternative interventions had been attempted prior to side rails being used. Surveyor: 43021 5. Observation and interview with resident 44, on 10/26/21 at 10:45 a.m. revealed: *Bilateral side rails towards the head of her bed. *She has side rails "so I don't fall out" and uses them to turn over when in bed. *She does not recall staff discussing the risks and			435042	B. WING_			10/28/2021		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 700 Continued From page 4 -The risks and benefits had been reviewed with the resident or their representative. -The provider received signed consent for side rails before their use. *Appropriate alternative interventions had been attempted prior to side rails being used. Surveyor: 43021 5. Observation and interview with resident 44, on 10/26/21 at 10:45 a.m. revealed: *Bilateral side rails towards the head of her bed. *She has side rails "so I don't fall out" and uses them to turn over when in bed. *She does not recall staff discussing the risks and			R RETIREMENT COMMUNITY		1002 NO	ORTH JAY STREET			
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Review of resident 44's medical record revealed: *She had been admitted on 12/30/20. *Her BIMS of 15 indicated her cognition was intact. *A 12/30/20 physician order for side rails to enable bed mobility and transfer. *Her last revised care plan on 9/30/21 stated she used partial side rails to enable bed mobility and transfers. 6. Observation on 10/27/21 at 8:10 a.m. of resident 4 in her bed revealed raised bilateral side rails towards the head of her bed. Review of resident 4's medical record revealed: *She had been admitted on 5/13/21. *Her MDS revealed a BIMS score of 3 indicating severe cognitive impairment. Her BIMS of 3 indicated her cognition was severely impaired. *A 5/13/21 physician order for side rails to enable bed mobility and transfer. *Her last revised care plan on 8/5/21 stated she	F 700	-The risks and benefit the resident or their re-The provider receive rails before their use. *Appropriate alternati attempted prior to sid Surveyor: 43021 5. Observation and in 10/26/21 at 10:45 a.m *Bilateral side rails to *She has side rails "s them to turn over whe *She does not recall she benefits of using the she had been admit *Her BIMS of 15 indicintact. *A 12/30/20 physician enable bed mobility at *Her last revised care used partial side rails transfers. 6. Observation on 10 resident 4 in her bed rails towards the head Review of resident 4 in her bed rails towards the head severe cognitive impater BIMS of 3 indicat severely impaired. *A 5/13/21 physician bed mobility and transfer and the severely impaired.	ts had been reviewed with expresentative. It disigned consent for side we interventions had been a rails being used. It expressed the head of her bed. It is a look of look of look of look fall out and uses an in bed. It is medical record revealed: It is on of revealed to enable bed mobility and If it is in the cord revealed: It is plan on 9/30/21 stated she to enable bed mobility and If it is medical record revealed: It is med	F	700				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG		TE SURVEY MPLETED
		435042	B. WING _		1	0/28/2021
	ROVIDER OR SUPPLIER	R RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 700	used partial side rails transfers. Review of residents of further revealed: *No assessment was were used. *No consent form was 'No education on the rails were documented 'No quarterly assessive regarding side rail use 'Use of the side rails at the care conference of the side rails at the care conference on the bed controls for part of the side rail. *The current practice on the beds. *She stated the side of their bed mobility. *She stated there was assessment in Medited electronic medical reconstruction on the beds have side rails. Interview on 10/27/21 housekeeper D when the beds have side rails. *RCS B stated: -No assessments we side rails.	and 44's medical records completed before side rails signed. risks associated with side id. ment was completed age. was not reviewed quarterly e. at 4:49 p.m. with resident b) B revealed the following side rails: their electric beds were a was to leave the side rails rails help residents maintain signor real side rail ech," the provider's cord (EMR). at 8:34 a.m. with asked about how many of iils, he replied "I don't think	F 7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			PLETED
		435042	B. WING			10	/28/2021
	ROVIDER OR SUPPLIER OTHER JOSEPH MAN	OR RETIREMENT COMMUNITY		1002	EET ADDRESS, CITY, STATE, ZIP CODE NORTH JAY STREET RDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 700	-The resident and consent for the useShe could not sho resident and family Medical record revion 10/28/21 at 9:30 EMR revealed and *She was aware of Restraint Policy. *There was a pre-rin the provider's EM* -This assessment in Device type (side devices listed on the Consent/orders, who consent was signed addressed the provider's EMR* This assessment in the provider's EMR* This assessment is statements where and addressed a commer controlly using sidented and the could be added to the same and the same and the could be added to the same and the policy for the care conference by the resident carlingly as a section review.	d to maintain independence. or family member do not sign a of the side rail. w documentation where the were educated on the risk. iew and interview with RCS B of a.m. regarding the provider's confirmed: the provider's August 2020 estraint assessment available MR. included: rails were one of the fifteen the checklist). There staff could indicate a d d to resident and family. Included the following staff could indicate yes or no ont: de rail. considered a restraint. ssessments were currently sses side rails. pre-restraint assessment the admission set. y are not completing a quarterly side rails. the use of these assessments side rails. ince summary was completed	F	700			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	435042	B. WING		10/	28/2021
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR	RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
*RCS B confirmed sh provider's August 202 side rails. Interview with director 9:58 a.m. confirmed: *Side rails were on materials were on materials were on materials were on materials with a sessments when us to a sessment with a sessment when us to a completed. Review of the provided Policy regarding side to a side rails will not be care. *Before utilizing side materials assessment will be confirmed to a side rail use and alternative and alternative assessment will assess materials assessment will be confirmed assessment will b	the care conference. e was not following the diagnostic of nursing A on 10/28/21 at cost of the beds in the facility. Included side rails on the med from the physician. It requirement to complete sing side rails. It sessessments had not been In a August 2020 Restraint rails revealed: In offered as part of routine In a pre-restraint In order to be able to use the medisciplinary team will In the risk associated with matives available such as a ment will be documented in ment. I be reviewed quarterly by man, resident, and family at	F 70			

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			ATE SURVEY OMPLETED				
		435042	B. WING _				10/28/2021
NAME OF PROVIDER OR S		R RETIREMENT COMMUNITY		STREET ADDRES 1002 NORTH JA ABERDEEN, S			
	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EA	PROVIDER'S PLAN OF CORF CH CORRECTIVE ACTION S SS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
CFR Part Emergence Term Care 10/26/21 t Manor Re compliance	41088 ation surve 482, Subpa y Prepared Facilities, hrough 10// irement Co e.	ey for compliance with 42 art B, Subsection 483.73, lness, requirements for Long was conducted from 28/21. Avera Mother Joseph ommunity was found in		000			
ABUKATUKT DIKECTUR'S C	D DDOMINED!	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE		TITLE		(X6) DATE

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program participation. NOV 17 ZULI Event ID: UFGF11 FORM CMS-2567(02-99) Previous Versions Obsolete

SD DOF

PRINTED: 11/09/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		435042	B. WING_		10/	26/2021
	ROVIDER OR SUPPLIER	RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000		F
	Life Safety Code (LSC occupancy) was cond Mother Joseph Manor was found not in come (a) requirements for L. The building will meet 2012 LSC for Existing and the Fire Safety Edated 10/28/21 upon deficiencies identified. Please mark an "F" in column for those define meeting the FSES. The building will meet 2012 LSC for existing upon correction of de K353, K918, and K92 provider's commitmer with the fire safety standard scenario (FR(s): NFPA 101). Number of Exits - Sto CFR(s): NFPA 101 Number of Exits - Sto Not less than two exit and accessible from exprovided for each store compartment shall like distinct egress paths the entry into the same compartment. 18.2.4.1-18.2.4.4, 19.	the completion date ciencies identified as the requirements of the health care occupancies ficiencies identified at K321, 3 in conjunction with the not to continued compliance andards any and Compartment for any and Compartment for the complete from each other, every part of every story are ry. Each smoke ewise be provided with two to exits that do not require the adjacent smoke	K	241		F
ABOBATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

Administrator

11/17/2021

Tom Snyder

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

Event ID: UFGF21

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		X3) DATE SURVEY COMPLETED	
		435042	B. WING_	*	10/26/2021		
	ROVIDER OR SUPPLIER OTHER JOSEPH MANOR	RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401			
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K 321 SS=D	by: Surveyor: 18087 Based on observation provider failed to main fire-resistive path of eto the exterior of the bobserved stair encloss main level corridor system in level corridor system in the east and west seed discharged into the mone-hour, fire-resistive provided to the exterior the previous life safety that finding. The building meets the "F" in the completion correction of the defice Hazardous Areas - Err CFR(s): NFPA 101 Hazardous Areas - Err Hazardous areas are having 1-hour fire resifire rated doors) or an system in accordance When the approved a system option is used separated from other partitions and doors in Doors shall be self-cloand permitted to have protective plates that from the bottom of the Describe the floor and	and record review, the ntain a one-hour, gress from the second level building. Two randomly ures discharged into the stem. Findings include: 26/21 at 9:30 a.m. revealed cond level stair enclosures ain level corridor system. A sepath of egress was not for of the building. Review of an ey code survey confirmed e FSES. Please mark an date column to indicate iencies identified in K000. Inclosure Inclosure	K 24		was drywall. dded to ll be roperly o the QA	11/24/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		/	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		435042	B. WING _		10/26/2021
	ROVIDER OR SUPPLIER	R RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
K 321	Area Separation N/ a. Boiler and Fuel-Fi b. Laundries (larger c. Repair, Maintenar d. Soiled Linen Roor e. Trash Collection F (exceeding 64 gallor f. Combustible Stora (over 50 square feet g. Laboratories (if cla Hazard - see K322) This REQUIREMEN by: Surveyor: 18087 Based on observatio failed to maintain the of two building separa generator electrical r vestibule). Findings 1. Observation on 10 revealed the two-hou between the general exit discharge vestib opening above the n The transfer grille op twelve inches by eig unacceptable installa rating of the wall.	Automatic Sprinkler A red Heater Rooms than 100 square feet) ice, and Paint Shops ins (exceeding 64 gallons) Rooms is) ge Rooms/Spaces) assified as Severe T is not met as evidenced In and interview, the provider of fire-resistive design of one ration walls (between the room and the exit discharge include: 10/26/21 at 10:30 a.m. 11/20 relectrical room and the 12/20 lectrical room and the 13/20 lectrical room and the 14/20 lectrical room and the 15/20 lectrical room and the 16/20 lectrical room and the 16/20 lectrical room and the 17/20 lectrical room and the 18/20 lectrical room and the	K 3	21	

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		435042	B. WING			10/	26/2021
NAME OF PROVIDER OF		RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		•	
	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Sprinkle CFR(s) Sprinkle Automa inspect with NF Testing Protect mainter maintai availab a) Dat b) Wh c) Wa Provide any nor system 9.7.5, 9 This RE by: Survey Based of provide sprinkle Prevent Standar Mainter System QR hea	er System - Matic sprinkler and ed, tested, and FPA 25, Standar, and Maintain ion Systems. Finance, inspectined in a securile. The sprinkler system superior in the system superior in the system superior in the system superior in the system as resulted to mainter system as res	aintenance and Testing aintenance and Testing and standpipe systems are d maintained in accordance ard for the Inspection, ing of Water-based Fire Records of system design, ion and testing are e location and readily stem last checked attention testing are information on coverage for artial automatic sprinkler d NFPA 25 is not met as evidenced aw and interview, the attain the automatic fire equired by the National Fire in (NFPA) Section 25, ection, Testing, and r-Based Fire Protection eak test and survey for GB		353 353		I the ited by ipt for eded	11/24/2021

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			TE SURVEY MPLETED
		435042	B. WING			0/26/2021
	ROVIDER OR SUPPLIER	R RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP 1002 NORTH JAY STREET ABERDEEN, SD 57401	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ARAGO REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	sprinkler heads (from was no documentation been acted upon or pure litterview with the matthe document review recommendations were commendations and the deficiency affect building's automatic maintenance. Subdivision of Building CFR(s): NFPA 101 Subdivision of Building Doors 2012 EXISTING Doors in smoke barrish bonded wood-core directly resists fire for 20 min plates of unlimited hear permitted to have assemblies per 8.5. If automatic-closing, do are not required to sweet ear width of 32 inch doors. 19.3.7.6, 19.3.7.8, 19.3.7.8, 19.3.7.6, 19.3.7.8, 19.3.7.	arvey for the quick response in the 6/7/21 report). There on this recommendation had berformed. Anintenance staff at the time of revealed the status of the ere unknown. The ed two components of the fire sprinkler system required ang Spaces - Smoke Barrier The ers are 1-3/4-inch thick solid cors or of construction that the eight are permitted. Doors to effice fire window Doors are self-closing or on on trequire latching, and wing in the direction of opening provides a minimum ness for swinging or horizontal		374		F

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		435042	B. WING		10/:	26/2021
	OVIDER OR SUPPLIER	RETIREMENT COMMUNITY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 002 NORTH JAY STREET ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 918 I SS=F (the cross-corridor documents in clear width. Survey report revealed the original construction the building meets the crowider's intent to con K000. Electrical Systems - ECFR(s): NFPA 101 Electrical Systems - EMaintenance and Test The generator or other and associated equipper service within 10 secont transfer switches are instantenance and test transfer of all EES load competent personnel. Stored energy power stantenance with NFPA stored energy power stantenance wi	26/21 at 9:45 a.m. revealed ors from the 1961 original addition measured 30 Review of the previous of those doors were part of fon. The FSES. Please mark an object of a column to indicate the prect deficiencies identified assential Electric System attempting or alternate power source ment is capable of supplying ands. If the 10-second ring the monthly test, a ded to annually confirm this afety and critical branches, ing of the generator and performed in accordance aspected weekly, exercised as 12 times a year in 20-40 ricised once every 36 us hours. Scheduled test	K 918		rms n of staff by the ion for ormal o the	11/24/2021

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION 1 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		435042	B. WING			10/	26/2021	
	ROVIDER OR SUPPLIER	R RETIREMENT COMMUNITY		1.	TREET ADDRESS, CITY, STATE, ZIP CODE 002 NORTH JAY STREET NBERDEEN, SD 57401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 918	program for periodica components is estab manufacturer require maintenance and tes readily available. Esticircuits are marked, a separate from normal the possibility of dam source is a design coinstallations. 6.4.4, 6.5.4, 6.6.4 (N 111, 700.10 (NFPA 7 This REQUIREMENT by: Surveyor: 18087 Based on record reviprovider failed to doo percentage of names testing from January Findings include: 1. Record review on revealed there was in percentage of general under load by the 12 generator during the January 2021 throug review of the general formula on it that woo compute the percent required. Interview we the time of the docur finding. The deficiency affect occupants.	ally exercising the lished according to ments. Written records of ting are maintained and Selectrical panels and readily identifiable, and I power circuits. Minimizing age of the emergency power insideration for new FPA 99), NFPA 110, NFPA 0) To is not met as evidenced ew and interview, the nument the generator load plate during monthly load 2021 through October 2021. 10/26/21 at 11:10 a.m. of any documentation of the patern ameplate value carried to kilowatt diesel Kohler monthly load tests from the October 26, 2021. Further for documentation revealed a cold allow the provider to age of load data that was inthe maintenance staff at mentation confirmed that		918				
K 923 SS=D		inder and Container Storag	K	923				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		435042	B. WING		10/26/2021		
	ROVIDER OR SUPPLIER DTHER JOSEPH MANOR	RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 923	Greater than or equal Storage locations are ventilated in accordary 5.1.3.3.3. >300 but <3,000 cubic Storage locations are within an enclosed in limited- combustible of gates outdoors) that of gases are not stored separated from combustible conscious and the separated from combustible conscious noncombustible conscious than or equal to the single smoke concepting available for care areas with an agon or equal to 300 cubic stored in an enclosure handled with precauting A precautionary significant door or gate of a where the sign includes minimum "CAUTION: STORED WITHIN NO Storage is planned so of which they are receptively cylinders are such considered empty is eare marked to avoid of in the open are protect 11.3.1, 11.3.2, 11.3.3,	nder and Container Storage to 3,000 cubic feet designed, constructed, and nce with 5.1.3.3.2 and c feet outdoors in an enclosure or terior space of non- or construction, with door (or can be secured. Oxidizing with flammables, and are ustibles by 20 feet (5 feet if ted in a cabinet of truction having a minimum rating. 300 cubic feet inpartment, individual immediate use in patient gregate volume of less than feet are not required to be e. Cylinders must be ons as specified in 11.6.2. readable from 5 feet is on a cylinder storage room, es the wording as a OXIDIZING GAS(ES) O SMOKING." o cylinders are used in order eived from the supplier. egregated from full ity employs cylinders with ge, a threshold pressure established. Empty cylinders confusion. Cylinders stored	K 923	The oxygen storage rooms will comply a stated regulations. The combustible may and wood shelf have been removed from Wing oxygen room noted. Oxygen storage rooms will added to the HVAC PM schedule and be audited were the Plant Operations staff for compliance the storage requirements. Audit results will be reported quarterly to QA Committee by the Plant Operations Director or designee until advised by the committee to discontinue.	terials In the B In weekly Ekly by In with	11/24/2021	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 5 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		435042	B. WING		1	0/26/2021	
	ROVIDER OR SUPPLIER OTHER JOSEPH MAN	OR RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 923	Surveyor: 18087 Based on observatifailed to protect me Combustible items five feet of the oxyg oxygen storage roo Observation on 10/ combustible materishelf above and wit cylinders in the B w minimum five feet of combustibles and of maintained as requi	ion and interview, the facility dical gas storage as required. were stored on a shelf within gen cylinders in the B wing om. Findings include: 26/21 at 11:00 a.m. revealed als were stored on a wood thin five feet of 47 oxygen e ving oxygen storage room. The of separation between oxygen storage were not	K 92	3			

PRINTED: 11/09/2021 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION A - SOUTHWEST WING	(X3) DATE SURVEY COMPLETED	
		435042	B. WING_			10/	26/2021
	ROVIDER OR SUPPLIER	RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS		K	000			
K 353 SS=E	Life Safety Code (LSG occupancy) was cond Mother Joseph Manowas found not in come (a) requirements for L. The building will meet 2012 LSC for existing upon correction of the K353 and K918 in concommitment to continus fety standards. Sprinkler System - McCFR(s): NFPA 101 Sprinkler System - Manutomatic sprinkler air inspected, tested, and with NFPA 25, Standar Testing, and Maintain Protection Systems. Final maintenance, inspect maintained in a secur available. a) Date sprinkler system superior in REMARKS any non-required or paystem. Provide in REMARKS any non-required or paystem. 9.7.5, 9.7.7, 9.7.8, and	ing of Water-based Fire Records of system design, ion and testing are re location and readily stem last checked stem test oply source 6 information on coverage for partial automatic sprinkler	K	353	The facility Plant Operations Director will fire sprinkler inspection reports and promothe reports. Western States has been contacted and noted 3 year leak test is scheduled for November 23, 2021. Sprinkler Inspection Reports will be audithe Plant Operations Director upon receive recommendations and scheduling of necessivices. Audit results will be reported quarterly to QA Committee by the Plant Operations I or designee until advised by the committed discontinue.	the ted by pt for eded	11/24/2021
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
	Snyder				Administrator		11/17/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: UFGF21

Facility ID: 0059

If continuation sheet Page 1 of 4

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION G 2A - SOUTHWEST WING	(X3) DATE SURVEY COMPLETED	
		435042	B. WING_		10/:	26/2021
	ROVIDER OR SUPPLIER DTHER JOSEPH MANOF	R RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 353	by: Surveyor: 18087 Based on record revie provider failed to main sprinkler system as reprevention Association Standard for the Insperience of Water Systems (three-year I QR heads). Findings 1. Review on 10/26/2 provider's sprinkler merevealed reports date the contractor stating perform the required dry systems and a suresponse sprinkler her There was no documer recommendation had performed.	ew and interview, the ntain the automatic fire equired by the National Fire on (NFPA) Section 25, ection, Testing, and r-Based Fire Protection leak test and survey for GB Include: 1 at 10:30 a.m. of the aintenance records d 6/7/21 and 10/1/21 from recommendations to three-year leak test of the rvey for the GB quick eads (from the 6/7/21 report). entation this	K 35	53		
K 918 SS=F	the document review recommendations we recommendations we The deficiency affects building's automatic fi maintenance. Electrical Systems - E CFR(s): NFPA 101 Electrical Systems - E Maintenance and Tes The generator or other and associated equip service within 10 second	revealed the status of the re unknown. ed two components of the re sprinkler system required Essential Electric System ting er alternate power source ment is capable of supplying	K 91	8 Generator Load tests will be conducted a required. The Generator periodic test fo have been revised to simplify recordation required Load tests. 3E – Electrical, Engineering & Equipment Co. provided generator operation & testing training on November 12, 2021 to Plant Operations that included load test documentation.	erms n of	11/24/2021

PRINTED: 11/09/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.07	(X2) MULTIPLE CONSTRUCTION A. BUILDING 2A - SOUTHWEST WING		(X3) DATE SURVEY COMPLETED	
		435042	B. WING		10/	26/2021	
	ROVIDER OR SUPPLIER	R RETIREMENT COMMUNITY		STREET ADDRESS, CITY, STATE, Z 1002 NORTH JAY STREET ABERDEEN, SD 57401	CIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE	
K 918	process shall be provided by capability for the life is Maintenance and test transfer switches are with NFPA 110. Generator sets are in under load 30 minute day intervals, and exemonths for 4 continuous under load conditions simulated cold start a transfer of all EES load competent personnel stored energy power accordance with NFP circuit breakers are in program for periodical components is estable manufacturer requires maintenance and test readily available. EES circuits are marked, in separate from normal the possibility of dam source is a design continuous. 6.4.4, 6.5.4, 6.6.4 (NI 111, 700.10 (NFPA 70 This REQUIREMENT by: Surveyor: 18087 Based on record review on the possibility of	rided to annually confirm this safety and critical branches. Iting of the generator and performed in accordance aspected weekly, exercised as 12 times a year in 20-40 ercised once every 36 ous hours. Scheduled test include a complete and automatic or manual ads, and are conducted by . Maintenance and testing of sources (Type 3 EES) are in PA 111. Main and feeder aspected annually, and a sally exercising the lished according to ments. Written records of ting are maintained and Selectrical panels and readily identifiable, and I power circuits. Minimizing age of the emergency power ansideration for new FPA 99), NFPA 110, NFPA 10, is not met as evidenced	K 91	Generator testing forms of Plant Operations Director documentation of require operation settings. Audit results will be reported QA Committee by the Plator designee until advised discontinue.	r upon completion for d testing and normal rted quarterly to the ant Operations Director		

Facility ID: 0059

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 2A - SOUTHWEST WING		(X3	(X3) DATE SURVEY COMPLETED	
		435042	B. WING_			10/26/2021	
	NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CO 1002 NORTH JAY STREET ABERDEEN, SD 57401	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTIVE ACTI	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 918	percentage of general under load by the 12st generator during the January 2021 through review of the generat formula on it that wou compute the percentar required. Interview with time of the document of the	ator nameplate value carried is kilowatt diesel Kohler monthly load tests from the October 26, 2021. Further or documentation revealed a suld allow the provider to age of load data that was the maintenance staff at mentation confirmed that the ded 100% of the building.	KS	918			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION IA - NORTHWEST WING	COMPLETED		
		435042	B. WING		10/26/2021		
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
K 000	Surveyor: 18087 A recertification surve Life Safety Code (LS	ey for compliance with the C) (2012 existing health care	K 000				
	Mother Joseph Mano was found not in com (a) requirements for L The building will mee 2012 LSC for existing upon correction of the K353 and K918 in co	ducted on 10/26/21. Avera represent Community upliance with 42 CFR 483.70 Long Term Care Facilities. If the requirements of the phealth care occupancies deficiencies identified at injunction with the provider's nued compliance with the fire					
K 353 SS=E	Sprinkler System - MCFR(s): NFPA 101 Sprinkler System - MAutomatic sprinkler a inspected, tested, an with NFPA 25, Standaresting, and Maintain Protection Systems. Imaintenance, inspection maintained in a securiavailable. a) Date sprinkler system support of the system of the system. Provide in REMARKS any non-required or paystem. 9.7.5, 9.7.7, 9.7.8, and and any non-required or paystem.	re location and readily stem last checked stem test pply source S information on coverage for partial automatic sprinkler	K 353	The facility Plant Operations Director review fire sprinkler inspection reports promptly schedule repairs or services recommended in the reports. Western States has been contacted a noted 3 year leak test is scheduled for November 23, 2021. Sprinkler Inspection Reports will be at the Plant Operations Director upon rerecommendations and scheduling of reservices. Audit results will be reported quarterly QA Committee by the Plant Operation Director or designee until advised by the committee to discontinue.	and the rudited by ceipt for needed		
ABORATORY		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE		
	Snyder			Administrator	11/17/		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that Any detriciency statement enoung with an asterisk (*) denotes a detriciency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Event ID: UFGF21

JD DOH-OLG

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION 3A - NORTHWEST WING	(X3) DATE SURVEY COMPLETED		
		435042	B. WING	-	10/26/2021		
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	1		
K 353	by: Surveyor: 18087 Based on record revie provider failed to main sprinkler system as reprevention Association Standard for the Inspendintenance of Wate Systems (three-year I QR heads). Findings 1. Review on 10/26/2 provider's sprinkler merevealed reports date the contractor stating perform the required dry systems and a suresponse sprinkler heads and the document review recommendation was recommendation and the document review recommendations we	ew and interview, the ntain the automatic fire equired by the National Fire on (NFPA) Section 25, ection, Testing, and r-Based Fire Protection eak test and survey for GB Include: 1 at 10:30 a.m. of the aintenance records d 6/7/21 and 10/1/21 from recommendations to three-year leak test of the rvey for the GB quick eads (from the 6/7/21 report). entation this been acted upon or intenance staff at the time of revealed the status of the re unknown.	K 353				
K 918 SS=F	building's automatic fi maintenance. Electrical Systems - E CFR(s): NFPA 101 Electrical Systems - E Maintenance and Tes The generator or othe and associated equip service within 10 second	ed two components of the re sprinkler system required Essential Electric System ting er alternate power source ment is capable of supplying onds. If the 10-second ring the monthly test, a	K 918	Generator Load tests will be conducted a required. The Generator periodic test fo have been revised to simplify recordation required Load tests. 3E – Electrical, Engineering & Equipment Co. provided generator operation & testing training on November 12, 2021 to Plant Operations that included load test documentation.	rms n of		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 3A - NORTHWEST WING			(X3) DATE SURVEY COMPLETED	
		435042 B. WING		10/:	0/26/2021			
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY				s ⁻				
(X4) iD PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
K 918	process shall be provided process shall be provided process. Shall be provided provided process. Shall be provided provided process. Shall be provided provided provided provided provided provided provided provided provided. Shall be provided provided provided provided provided provided provided provided provided.	ided to annually confirm this safety and critical branches. Iting of the generator and performed in accordance spected weekly, exercised s 12 times a year in 20-40 ercised once every 36 ous hours. Scheduled test include a complete and automatic or manual ads, and are conducted by Maintenance and testing of sources (Type 3 EES) are in A 111. Main and feeder aspected annually, and a ally exercising the ished according to ments. Written records of ting are maintained and selectrical panels and eadily identifiable, and a power circuits. Minimizing age of the emergency power insideration for new	KS	918	Generator testing forms will be audited Plant Operations Director upon comple documentation of required testing and roperation settings. Audit results will be reported quarterly to QA Committee by the Plant Operations or designee until advised by the commit discontinue.	tion for normal o the Director		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION (X3) DATE SURVEY UILDING 3A - NORTHWEST WING COMPLETED			
		435042 B. WING 1		10/26/2021			
NAME OF PROVIDER OR SUPPLIER AVERA MOTHER JOSEPH MANOR RETIREMENT COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 NORTH JAY STREET ABERDEEN, SD 57401				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)				
K 918	percentage of general under load by the 125 generator during the January 2021 through review of the generation formula on it that wou compute the percentar required. Interview withe time of the documfinding.	etor nameplate value carried is kilowatt diesel Kohler monthly load tests from a October 26, 2021. Further or documentation revealed a seld allow the provider to age of load data that was the maintenance staff at mentation confirmed that sed 100% of the building.	K	918			

South Dakota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		10590	B. WING		10/28/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
AVERA MO	OTHER JOSEPH MANOF	PETIDEMENT COL	AY STREET EN, SD 57401			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
\$ 000	44:73, Nursing Facilit 10/26/21 through 10/2 Manor Retirement Co		S 000			
S 000	44:74, Nurse Aide, re training programs, wathrough 10/28/21. Av		S 000			
		NUMBER OF DECRES ENTATIVE'S SIGNATUR	-	TITLE	(X6) DATE	

Tom Snyder STATE FORM

Administrator

G3OM11

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11/17/2021

If continuation sheet 1 of 1